GENERAL REPORT ON THE MONITORING

Second Mission to East-Central Afghanistan (Ghazni, Wardak, Kabul, Kapisa & Parwan Provinces).

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INTRODUCTION

The following is a wide-ranging series of remarks related to observations and impressions that have come from our in-country mission, with sometimes rather philosophical digressions as we pursue the meanings behind what we saw.

2.1 ON FACILITIES

Overall, the buildings are solid and weather-tight. Generally they are mud wall construction with log and twig roof. Often they are nothing more than converted rooms in a bombarded house compound, but others have been constructed to be clinics. The clinics are usually well-organized, although there is usually no special provision for a patient waiting area. (Of course neither do patients expect to have a waiting area, they wait outside and on the ground the same as they do everywhere else.)

If a new building has been built, it is financed by the local resistance front, not by the sponsor organization (except for groups that send in expatriate personnel).

At least half of the clinics had no planned method for disposal of human waste, ie. latrines. In the planning of new facilities the inclusion of a latrine is usually omitted.

The disposal of medical refuse is usually haphazard. Sometimes it is systematically burned or buried, but usually it is just dumped in a hole or behind a ridge and litter is strewn about the clinic grounds.

Water supply is usually adequate as water comes from a nearby well or spring. Clinic water supply is no worse than water supply elsewhere. Only two or three clinics drew their water from irrigation canals.

Clinics are mostly heated by wood in the winter, a few are heated with kerosene. Wood is supplied by the commander, by clinic personnel, or is paid for as a clinic expense by the sponsor organization.

Most facilities have no room used exclusively for hospitalization. However, if necessary, overnight accomodation can be made somewhere in the clinic. In kararga clinics there is always a place where wounded mujahideen can stay for more extended periods of time. Usually, patients requiring nursing service remain in their homes and are visited by health workers. This arrangement is very common.

Generators are present in a few clinics. Mostly they do not improve clinic services, but provide power for lighting at night as the clinic workers sit around drinking tea after dinner. If there is hospitalization or electric equipment in use, then it can be worth providing a generator.

Clinic transportation ranges from nothing, to walking, to a bicycle, to a horse, to a motorcycle, to a motor vehicle. Almost every health worker thought he needed a motorcycle or ambulance, or both. It is true that often a worker is taking a lot of time walking to make home visits, especially if his clinic is far away from the village. Sometimes this means no coverage at the clinic while he is gone. The committees should take care to consider requests for a bicycle or motorcycle on a case by case basis, and make clear who is supplying the oil and gasoline. Incidentally, if a committee is supplying ambulance vehicles, we would just like to say that <u>we</u> really would like an ambulance (Toyota Hilux 4 x 4 will do) and please put us next on the list.

2.2 LOCALIZATION AND ACCESS

The location of the clinics is often not exactly known by the supporting committee in Pakistan. 19 on 29 of the locations that were communicated to us proved to be wrong. That tells something on the way how committees are following what happens in Afghanistan with 'their clinic'. Are the committees so afraid of losing security that they will not divulge correct information even to the CMC monitors, or do the committees really not know where their clinics are working. The point is, even with so much faulty information, we could find all the clinics we were looking for by just asking people we met "Where is such and such clinic?". Clinic locations are far from secret in the places that they service. The mis-information in Peshawar has major

implications for efforts at mapping clinic locations.

There is no good correlation between war activity and 1) clinic location in mountains vs. villages, or 2) mobile vs. stationary clinics. It is not unusual to find a war mentality for mountain clinics or mobile clinics when there has been no fighting for two or three years. We think this reflects local thinking on the prospects for peace any time soon. In the areas free from active warfare, we recorded 36 clinics. Of these 36, 4 were mobile, 12 were in remote mountain sites (5 building or planning to build), and 20 were in more or less populated areas (5 building or planning to build). Of these 32 stationary clinics, 8 are predominantly treating mujahideen.

We observed clinics remotely located that attract a lot of civilian patients, and centrally located clinics that have a low patient load. Location is not a primary factor in a patient's choice of clinics. The important factors appear to be 1) the health worker's professional reputation, 2) the supply of medicines available, 3) the atmosphere, ie. whether or not the clinic is a mujahideen clubhouse. This last factor is especially important in regard to utilization by women and children.

2.3 MEDICAL EQUIPMENT

A stethoscope, BP cuff, and thermometer can be found at every clinic. Some clinics have an otoscope, some don't. A few clinics have urinary catheters or a scale. Laryngoscopes were rare.

Maybe half the clinics had a table for patient exams, while the others just use a mattress on the floor. Usually the better clinics have made the effort to somehow get an exam table, although there is nothing wrong with a clean mattress on the floor.

Pressure cookers used as sterilizers are fairly common, but are not used so much. IMC supplies special wood-fired autoclaves which are also little-used. The main use of steam sterilizers is to sterilize dressings, and most places really don't use that many sterile dressings (but should). Perhaps the training programs could place a higher emphasis on the importance of steam sterilization of dressings.

Formalin was found surprisingly infrequently, in less than half the clinics. Often instruments are "sterilized" by boiling or soaking in Savlon solution. Boiling is not bad, but between the pot and the patient the instruments usually become contaminated when they are picked up by hand and put in an instrument box, which is also usually not sterile. The same problem exists with Savlon soak. With formalin, the instruments can stay in the same

box they are sterilized in.

Microscopes were found at the MDM hospital and at some IMC clinics. The only one in use was at MDM, where there is a full-time lab technician to handle the work. The IMC microscopes are not in use and have in fact never been used. There are three main reasons for this: 1) there is no special place for lab examination 2) there is no time to run lab tests when they are so busy with consultations 3) usually disease can be treated appropriately on the basis of clinical symptoms. This is true for most diarrhea, malaria, and anemia. There are dipsticks available, or should be available, for urine testing. One good use of the microscope is TB detection, but where a medic has no medicine to treat TB, he may as well refer a case of suspected TB to a referral center. This referral method is quite common, and why should a medic attempt to diagnose when he cannot treat? If a medic were doing lab testing, he wouldn't be doing many tests per month, and the quality of the lab work would certainly be marginal at best.

Dental instruments are sometimes present. Some committees supply dental instruments to their workers, while other workers buy dental instruments in Kabul. Where dental instruments are present, dental work is performed. Some health workers have learned tooth extraction but are not supplied with dental instruments, and so they do not perform dentistry.

There is wide variation in the need for surgical instruments and wound dressings. Some clinics are in sleepy little places that might treat a few domestic trauma injuries a month. Other clinics are essentially small trauma centers for fresh war-wounded and are utilizing surgical instruments and wound care supplies and dressings almost every day. The war now is localized to the major cities and along some transportation routes, so clinics in different places will have a different demand for surgical instruments and supplies. Clinic resupply of these items should reflect clinic trauma patient load.

2.4 ON MEDICINE

In general, health workers pay no attention to the inventory of their stock of medicine. No periodic counting of stock is ever done. Often they cannot even produce their medicine supply list. They work unconcernedly, until the medicine is gone.

All health workers complain that they do not receive enough medicine. Especially, most report a lack of injections and syrups. The workers attribute this shortfall to a high number of patients, but rather it appears to us to be caused by overconsumption. Patient demand for injections and syrups is always high. Generally antibiotics and analgesics were regarded to be undersupplied.

Two medicines are almost always mentioned as being in oversupply. These are chloroquine and metronidazole.

Patients much prefer to receive medicine in factory-prepared packets than to have it come from bulk containers.

It is not unusual for a clinic to have an alternate source of medicine, usually Kabul or another large city, for medicines not on the clinic's medicine supply list. The money for such medicine may come from the resistance front. Also the Arabs and Union Aid will supply injections and syrups if a health worker is willing to take it. The ICRC supplies extra wound care materials to almost anybody asking for them, they usually can receive one or two cartons in Peshawar.

Medicine is stored in a variety of ways clinic to clinic. It may be kept in the clinic, in the medic's house, in a special pharmacy building, in a localrga, hidden in a cave, hidden underground, or secretly in a house. Often only the responsible person has access, ie. a key, to a locked storage area. Storage conditions are usually acceptable to prevent spoilage of medicines, but since there is never inventory taken, pilferage will not be detected.

NOTE In the Panjsher, where health care is centrally administered, all incoming medicine from the SCA, IMC, FM, etc. is pooled at Rokha hospital and allocated to health workers according to the estimate of need.

2.5 ON MEDICAL SUPPLY LINE

For improvement, most health workers said that the support committee should itself bring the medicine from Peshawar to the clinic. They say this will insure a smooth and timely delivery and will help protect the medicine from damage.

Most deliveries come via hired truck from Pakistan. Sometimes the party front takes responsibility for transport, other times the health worker is on his own to make arrangements. The SCA often pays a transportation allowance to cover the cost of truck rental. The IMC sends one or two monitors with the medicine or medic who accompany the medicine to its destination. The GAC brings the medicine in itself with a GAC truck, and this method has been cited at some interviews as the ideal way to make the delivery.

A travel letter may or may not be recognized at Pakistani police checkpoints. Some groups have paid as much as 700 Rs. to police in Pakistan. Groups with a letter from the SCA can usually pass without paying anything.

In Afghan fashion, answers to "When is the route closed" varied a

lot. From the south, the route is closed maybe one or two months in the winter because of snow, or is not closed at all. From the north, the passes are closed in the winter, for how long depending on which pass.

At last resupply, only one clinic reported trouble moving medicine because of another resistance group. No medicine was lost to the Afghan government or to the Soviets.

2.6 ON SALARY AND EXPENSES

Most of the health workers earning 2,000 Rs/mo did not press the need for higher salary, while the MSH workers earning 800 Rs/mo were dissatisfied with this amount. The higher salary is a good income in Afghanistan, where it is almost impossible to earn a good living doing traditional work.

Most health workers were mujahed before their training, and in fact are still mujahed working under their commander and working with their fellow-mujahideen. However, they are set apart from the others, and it is a cause for concern in the group because:

* They receive a salary while no one else does. In common thinking, a true mujahed receives no money for his work.
* They have an easier life than fighting mujahideen, it is a quiet and safe life working as a "doctor saeb". And there is additional respect conferred on them by the people.
* They have a future with their work, while the average mujahed has no special skills or training for work after the war.

Now it is known that being a health worker means receiving a salary, and it is no coincidence that many family members of commanders are sent to become health workers.

Because of the opportunity for high salary, we have heard cases of "doctors" falsifying academic papers in order to receive support from a Peshawar committee, eg. a worker with 2 years of medical schooling has papers showing he is a graduate doctor.

The 3-month workers see that they are doing the same work, treating the same range of patients, in their clinics as the mid-level workers see in their clinics, and feel it is unfair for them not to be paid as much as the others. Of course they have little feeling for the quality or appropriateness of the one versus the other.

Where a "doctor in charge" is managing other workers, and receives more salary, it appears that to be a difference acceptable to everybody.

The Arabs use salary as leverage to try to pry workers away from their clinics to come work with them. They usually offer 500 Rs/mo more than what a worker is making.

There is concern voiced by some commanders about who will continue to support the health workers and clinics in the future.

On expenses, the health workers that receive money for monthly clinic expenses appear to use the money appropriately. The clinics are usually nicer facilities and the food is better. Those fully dependent on the commander for their monthly expenses are subject to finding their clinic installed in a kararga.

2.7 ON PERSONNEL

All the health workers trained in a CMC-member program that we located were working at their clinics, more or less as they were supposed to be doing. There was good cooperation from them as we met with them to assess their work. In general, we liked these people.

If a worker was not present, he was usually away in Peshawar, away on a home visit, or had been re-assigned to another place.

We met no instances of acrimonious working relationships among different workers in a clinic. In fact there is only one story of clinic infighting, which resulted in a peaceful divorce when one worker switched parties and established another clinic.

It is not uncommon to find a clinic, usually with the SCA or FM, where the primary health worker has a cadre of workers working under his direction. Some of these workers have been trained at places like Union Aid or ICRC, some are locally trained by the primary health worker, and a few are even graduate doctors. This approach can be good where there has been formal health training, but the local training of friends to be health workers is disturbing. Another result is that there are probably not enough patients to keep all the "workers" busy.

There is a division of labor at most clinics. The primary provider(s) see the patients, diagnose, and write prescriptions. They may or may not perform wound care themselves, sometimes it is done by an "assistant". Often at a separate place there is an "assistant" who receives the prescription chits and dispenses the medicine, usually without giving instruction to the patient.

Ancillary clinic personnel--cook, cleaner, guard--are usually mujahideen and are often friends or family of the health workers. Indeed this is nepotism sometimes, but this system ensures better working relationships and honesty in the work. Where committees support ancillary personnel, the clinic is more independent of the commander.

2.8 ON THE GREEN BOOK

At issue with the green books are the validity and reliability of the record. Validity concerns accuracy, correctness, completeness. Reliability concerns reproducibility, which is less of a concern since clinic practice is not a controlled event, but rather a reflection of a service area's picture of disease in a period of time.

There are two questions with the validity of the green books. The first is, "Is the record a faithful depiction of what the worker thinks he sees", ie. in regard to diagnosis, and in regard to completeness. The second is, "Is the worker's depiction of what he sees a true assessment of what is really there", ie. is it correct.

We have serious doubts about the validity on both counts, and this is why:

* Too often patients treated are omitted from the record, because of overwork, inadvertance, or apathy. Conversely, we have seen records containing "pre-recorded" patient visits, or "padding" of the record, to justify continued support from a committee.

* The main problem in the entries is in regard to diagnosis, because of the imperfect knowledge of the practitioner. There is reason to doubt a diagnosis of "gonorrhea" in a 2 year old boy. The same applies to most reported cases of cholera, typhoid, and unconfirmed TB.

There is a difference between seeing a green book on a surprise visit and seeing a green book in Pakistan after it has been well-prepared.

The green books are completed in a variety of ways. We have seen them filled out patient by patient, day by day, month by month, a week in advance, and not at all. Any method other than patient by patient enhances the risk for error.

Some workers tell us that patients refuse to cooperate to provide them with biodata for the green book, but in practice such reticence is rare.

A review of 21 places where green books are in use gave us the following impression:

Probably valid:	4
Possibly valid:	7
Probably not valid:	10

The green book chronicles patients by serial number, date, name,

age, sex, diagnosis, and treatment. The principal shortcomings appear to be incorrect dating, faulty diagnosis, and omission of cases treated.

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Is green book data entry for computer analysis really worth it? It depends on what you want to know. You can know a lot by just looking at the green books. From a simple review you can conclude that:

* Distribution by age and sex. A profile of the clinic patients seen shows generally about 25% women, 25% children, and 1-2% war wounded, if that. A kararga clinic sees fewer women and children, and may see more war wounded.

* In most places, war trauma injuries are not a significant part of clinic practice. Where there is war, there are war-injured.

* The average number of patients seen per day is highly variable clinic to clinic.

* Distribution of disease. 90% of patient visits are for common complaints that are readily treated, eg. GI disease, respiratory disease, arthritis/rheumatism, skin disease, etc. As for determining incidence and localization of disease, the green books are precise but not so correct. How much cholera is really cholera, how much typhoid is really typhoid, how much malaria is really malaria. Anyway, such data is too old to use for early eradication of an epidemic.

* Treatment is mostly suitable for diagnosis. Flagrant misuse of medicine is not a problem. The common diagnoses are usually managed with the correct medicine, and referrals are made as needed. The issue here is correctness of diagnosis, because the treatment follows from it.

* Health workers use what they have learned, and where they have not been taught, they improvise. There should be regular retraining and recertification to practice, with emphasis on diagnosis and record entry. Without this effort the green books will remain a tool that cannot work.

* It is faster to have a medical person scan a green book for diagnosis-treatment than to have a computer operator enter the data and then have the medical person scan the computer output.

* In regard to assessing practitioner treatment patterns, it is not possible to do so from a green book when there are multiple entry writers. Each practitioner needs the exclusive use of a book that is his own in order to make such an assessment.

Most of the practitioners we saw recognized their limited medical knowledge. They need, and most of them want, more training. This is the only way to address the problem of mistaken diagnosis

in the green books.

In summary, the green books constitute a voluminous data bank. But only a small percentage of the green books are trustworthy enough, are valid enough, to believe that detailed analysis is worth the time and effort. The concern here is using this faulty data base as a foundation for program planning. Number crunching may satisfy some funding agencies or member committees, but the fact remains, "Garbage in, garbage out".

2.9 LOCAL HEALTH PROBLEMS

TUBERCULOSIS

Tuberculosis appears to have developed into a major health problem. Most health workers mention tuberculosis as one of the three main causes of death in their district. There is no death certificate to document cause of death, but TB seems to be ubiquitous. Only the NCA and MDM are attempting to treat any TB patients in the places we visited.

The other committees have elected not to treat TB because of the problems of definitive diagnosis, expense of treatment, and length of treatment/patient compliance. In our opinion this has been a good decision because the average health worker doesn't have the resources to conduct an effective campaign against TB, even if he had the medicine on hand.

What happens to patients with diagnosis of "Suspected TB"? They are mostly referred to a government clinic or hospital in Kabul or Ghazni, or to Pakistan, for diagnosis and treatment. Some patients receive a prescription for anti-TB medicine to buy in the bazaar, but it is expensive and few people can afford to buy enough medicine for a full course of treatment. But the prescriptions are generally correct.

WOMEN'S HEALTH

Treating women patients is very common. But treating problems in gynecology and obstetrics is very rare, almost impossible. Some health workers have no interest in this sphere of medicine, but even for those who are interested the cultural barriers prohibit any involvement. Pregnant women do not come to the clinic, and health workers are not asked to attend a delivery. The local dais are old women without special training, and usually they are not even known to the health workers. The world of childbirth remains closed to male practitioners. Meanwhile, complications of childbirth continues to make a significant contribution to overall mortality.

There is one case where a health worker worked with a young dai (educated through grade 6 in Kabul) as advisor and teacher in making injections for obstetrical drugs like methergine and oxytocin. He has been in attendance outside the house, he says, while the dai was inside managing the delivery process.

OTHER DISEASES

Disease follows a seasonal pattern. In the winter there is higher incidence of respiratory infections. In the summer there is higher incidence of gastro-intestinal disease and malaria.

The incidences of cholera, typhoid, and malaria are not really known because the diagnoses are not confirmed by lab testing, so these may or may not be big problems. A patient with symptoms of vomiting and diarrhea is often diagnosed with "cholera", especially when he dies. An AVIÇEN physician who went to Nuristan in August 1988 to confirm an outbreak of cholera was unble to verify that the disease was present.

Some of the graduate doctors observed that the psychological reaction to the stress of war is a component of many patient complaints. Almost everybody has suffered loss from the war in one form or another, and is manifested in complaints such as headache, gastric pain, and "total body pain for 9 years".

2.10 VACCINATION

Vaccination is occurring in some places we visited. We saw three approaches to getting the people vaccinated:

1. A comprehensive planned program utilizing trained personnel, viable vaccines, and cold chain equipment. These are AVICEN programs working with other cross-border health groups, the ones we saw or heard about are MDM in Jaghatoo and MSF in Badakhshan.

2. A health worker is able to receive vaccines through his party front, and proceeds to vaccinate. These vaccines are bought in Kabul. The supply and selection is very irregular. There is never care taken for vaccine temperature control, for protocol in vaccine administration, or for record-keeping. Now nobody knows who has been vaccinated against what, or when. Of the clinics we visited, only one has a program of this type.

3. In response to the "cholera epidemic" in Sayed Abad and Chak this summer, three clinics mounted public vaccination campaigns. The impetus for such programs came from the commanders, who bought and brought vaccines from Kabul. One worker told us his party front brought 60,000 doses. Another worker said he and his workers vaccinated 10,000 people. They vaccinate "everybody", sweeping through from village to village.

Again there is no vaccine temperature control, protocol in administration, or record-keeping.

The workers who have vaccinated are absolutely convinced that their work has saved countless lives. There were no instances of laboratory confirmation of diagnosis of cholera. In their thinking, people stopped dying of "cholera" after vaccination, which therefore proves that the "cure" is attributable to the vaccine intervention.

NOTE: Recent WHO "Guidelines for Cholera Control" states: "The vaccines available at present are not helpful in the control of cholera . . . Vaccination campaigns, even with vaccines obtained free of charge, divert resources, attention, and manpower from more useful activities."

There is universal acceptance of vaccination by the people, the commanders, and the health workers. Every commander would like the approbation of bringing this modern service to the people, where everyone can see what he is doing for them. And the people are plenty willing to come and get a free injection.

A side-effect of vaccination is that it perpetuates a belief among the people that medicine contains health, that to take medicine means to receive concentrated health. It also reinforces their belief in the relative potency of injection over oral medicine.

2.11 IMPLICATIONS OF SOCIAL EXPECTATIONS FOR HEALTH CARE

The average Afghan villager has a rather magic vision on healthcare. Century old beliefs color his conceptions. The world of diseases, health, cure, and medicine is mysterious as are the workings of the body. His idea on health care is a curious mixture of theories, religion, and magic, eg. the dualistic (hot-cold) attributes of foods, colors, diseases; abstention from food or drink as therapy; the power of Quranic verses and charms; folk treatments such as burning points, massage, and traditional splinting.

Western modern medicine came in through Kabul and added a whole range of new cures and techniques to the existing health beliefs. For example, a pill is regarded as a piece of concentrated health that cures you when you are ill or makes you stronger if you are well. Color, shape and size are important as are different routes of administration (oral, IM- and IV injection). Western medicines have been popularized throughout the countryside by shopkeepers that hardly had an idea of what they were selling. The Afghan doctors working in major cities became accustomed to writing prescription chits for at least 5 medicines, including oral vitamins and an injection. Therefore, before the war both doctors and "pharmacists" were big promoters of over-consumption of medicines.

As the CMC-member committees have established clinics the result has been a widespread proliferation of sources of medicine for the people, and the medicine is available for free, they just give it away if you come and say you are sick. Even if you are not sick but feel like you need some kind of "health boost", the best thing is to get some "concentrated health" in the form of pills, or even an injection, from the clinic. Often a patient demands the medicine he wants by name.

Clinics are perceived by the people first to be places to get medicine, and don't think about them as a source for other services. Despite the training that the health care workers are receiving, the clinics are not recognized as primary orthopedic service centers in lieu of shekestebands, or for other non-pharmaceutical services.

The result is a dynamic process between:

* The health worker, who has the authority to dispense medicine and who is fighting against the tendancy to forget what he has learned
* The village people, who want better health through more medicine
* The commander who wants a "good clinic" that the people like, and that will enhance his prestige.
* The friends and relatives of the health worker who expect extra treatment
* Health workers, who are competing for reputation as "the best doctor".

This helps explain the tendancy for overprescription, overuse, and misuse of medicine by some health workers, and the high percentage of patients coming to the clinic with vague, non-acute complaints.

Of course the people like vitamins and minerals, and in fact their diets are generally deficient. The dispensing of lots of vitamins is not really so inappropriate given the nature of the food supply, and such overuse is not dangerous.

We recommend that the CMC groups look at the policy of distributing medicines for free, because indeed there are adverse effects of such largesse. Future in-country monitoring should explore acceptability of having patients pay a fee for treatment. There is a precedent for one such system at the former MSF clinic in Jaghori district, Ghazni.

2.12 ON QUALITY OF HEALTH CARE DELIVERY

The issues with quality of health care delivery are correctness of diagnosis and appropriateness of treatment.

We find cause for concern in regard to correctness of diagnosis. Granted that many patients appear with trivial or non-sensical complaints, complaints like "When I drink tea it hurts from my chin down a line to my belly-button and then it branches down each leg". This kind of complaint discourages meaningful history-taking and physical exam. However, there are cases where patients can have real symptoms of disease that are incorrectly explained, and the health worker fails to make his own assessment based on history and physical exam. This is one problem, that diagnoses are sometimes based on superficial information. The other problem is that a health worker is confronted with disease entities that he is not equipped to diagnose, but must diagnose none the less. In such cases, his best guess is likely a wrong guess.

Almost always treatment is reasonably appropriate for diagnosis, as concluded from the green books and from observation. This applies to choice of medicine, route, dosage, and duration of treatment. There is a tendancy toward over-prescription of unnecessary meds, sometimes these are antibiotics, often they are only vitamin supplements (this is not necessarily a problem in treatment). There is also a tendancy to use injections to administer antibiotics and even vitamins when it isn't warranted. It is the independent health workers and the lesser trained health workers who utilize injections the most.

Practitioner expertise in wound care technique varies a lot. In most places there is poor adherence to sterile technique and a laxity in preparing sterile instruments and supplies.

Wherever there is health care being delivered, anything that has already been described is always worse for women patients.

In regard to some areas of public health--waste disposal, personal hygiene, health education--the clinics are poor examples of model practice.

Most health workers recognize a need for continued medical education for themselves, and would like to take further studies. For these people, the lack of knowledge is a frustration for them in their work.

2.13 ON TRAINING PROGRAMS

Candidate selection:

There is still a maldistribution of clinics and health workers in terms of geography. Some areas are loaded with CMC-member workers (and others), while other areas receive no attention. This results from a lack of information about local health infrastructure where there are too many workers, and from a lack of contact (eg. Hazarajat region, no representation in Peshawar, restrictions imposed by committee funding sources) where there

are too few or no workers.

The letter of recommendations that committees require of their candidates are important and necessary. The letters coming from local commanders are the most important, and every effort should be made to groom relations with commanders of accepted candidates. The letters coming from the party health committees are a courtesy to placate their need to know, but have no real utility in assuring the viability of a candidate.

It appears that some graduates have used falsified papers to enter a program, never having been recommended at all. Knowing his commander would have alerted the committee(s) to the fraud. In the Panjsher we were looking for health workers who no one, neither villagers nor mujahideen, had ever heard of.

Teaching curriculum:

Most teaching curriculums in the training programs were formulated with meeting the health care delivery needs of a country at war. Meanwhile, it is abundantly clear that almost all health care delivery at the clinics is directed on third-world ambulatory care patients and not on war-injured patients. The teaching curriculums three years ago had mistaken emphases vis a vis internal medicine and surgery, and consequently were not well-suited to meet the future needs of clinical practice.

Two areas that had suffered early neglect were public health and maternal-child care.

Dental skills are well worth teaching, the people in Afghanistan have a lot of bad teeth. Most training committees are teaching dentistry, it would be interesting if they all supplied their workers with dental instruments.

Amputation of an arm or a leg is almost never performed by a mid-level health worker in the areas we visited, although all say they have learned it. Occasionally a worker reports having amputated a finger or a toe, but rarely are such patients unable to be referred to a proper facility. Without performing amputation regularly, one cannot expect a worker to have consistently good results.

One of the most common surgical procedures in Afghanistan is circumcision. It is mostly performed by untrained persons in dirty conditions. There are a lot of post-circumcision complications, and many of these cases in turn come to the nearby clinic for treatment. One supposes that if a worker can be trained in amputation, he can certainly be trained in circumcision (being careful not to confuse the two). It is one area of surgery that the training committees can meaningfully address.

The most useful branch of surgery for health workers to know is incision and drainage of abcesses, wound debridement, and burn management, including proper sterilization and handling of instruments. Once these basics are well-covered, then maybe it is time to think about some people being taught higher level surgical skills.

Management of orthopedic injuries by health workers is not uncommon, although often a patient first seeks treatment from a native bone healer, develops complications, and then appears at a clinic to get stronger medicine (an injection or serum). The health workers need a good understanding of orthopedics, sequelae, and when to refer.

Teaching basic laboratory techniques may be good for the theoretical knowledge in understanding germ theory, but don't expect a mid-level health worker to spend his time looking through the microscope during clinic hours.

The preparedness of a health worker for his work in Afghanistan is not so much dependent on the length of training he receives, but on how much training time is spent learning the things he will need to know. You cannot gauge the effectiveness of a training program by looking at the content of the teaching manual, or by how many months long a course runs; you must also look to know where the graduate health worker will be working and what types of disease and injury he will actually be encountering.

Continuing Medical Education:

There are four problems with training as it is now:

1. There is no way for graduate health workers to obtain further medical training. The lack of opportunity for a good worker to enhance his skills is almost tragic, given the number of good workers who could be so much the better. How many times did we encounter workers who are eager to know more, with so many questions from their experience, but who can only go back to Peshawar once or twice a year and maybe get a few weeks of "refresher".

2. There are too many low and mid-level health workers being produced. CMC has record of 3,229 of these being supported by CMC-member groups.

3. There is a lack of standardization in levels of practitioner competency. The committees should take a look at what happened in the past with medical training, that now there are a half-dozen levels.

4. There may be a need for more trained lab technicians and X-Ray technicians. And instead of producing as many of these people as possible, keep the numbers within reason and determine to work

2.14 ON RELATIONS WITH HEALTH WORKERS

On relations of committees with their own health workers:

There is a temptation for the committees to congratulate themselves when a class is graduated--that a cycle of work is completed, that the Afghan people are getting more help--and the health worker is sent on his way with six months of medicine, and attention is turned to the next class.

Meanwhile the health worker is experiencing a heavy learning period and is adapting to his new role. He is just beginning to need to rely on his committee for stimulation and support in his work. He has a way to go before fulfilling the committee's expectations of him that he is able to use all the knowledge he had been taught.

It is necessary for the committees take a paternalistic interest in their health workers all along the way. This means taking time to really get to know their situation. It means checking on them in-country. It means working with them with medicine supply and clinic needs. It means knowing and working with their commander. It means taking care to know if he is working as he should. And it means providing him with the means to advance his level of medical understanding through continuing education.

On relations of committees with other health workers:

In general, mid-level health workers seem satisfied enough with their sponsor committees to continue working with them. Sometimes a worker has begun with one committee and then gone to the SCA for sponsorship, for various reasons. The low-level workers with MSH are looking for something better. The standardization of salaries has probably limited "committee hopping".

On relations of health workers with other health workers:

Health workers in an area usually know about each other, but they do not meet professionally to discuss problems and concerns. It is not because they are opposed to such contact, but they do not have the freedom to do so. Where there is animosity, it usually stems from heresay and innuendo based on a silent rivalry. If a central health system were in place validated by local political support, we believe the health workers from different committees in an area would work well together.

The relations between a health worker and a traditional health care provider, eg. dai, barber, shekestaband, are essentially non-existent.

together on a single standard program for such specialized courses. This avenue in continuing education can be an option for some existing health workers as a way to establish a long-term career other than that of "doctor".

Ways of addressing these problems could be to:

* Stop producing so many new health workers

* Recuperate the existing health workers. Give them a standard higher level medical education course or a standard high level specialization course in X-Ray, Laboratory, Surgery, etc.

* Create an on-site field supervision program where medical doctors and nurses work with the health workers in their clinics.

It is necessary that the training committees form a cooperative program. We envision the possibility of a training center, a school, where the mid-level health workers from many training programs can enter in and receive training as a standardized high mid-level health worker, perhaps equivalent to a U.S. Physicians Assistant/ Nurse Practitioner (a level between nurse and MD). This would mean a redirection of resources away from training new health workers and toward the training of existing health workers. The continued uncontrolled input of new health workers into the health care picture is no longer justifiable.

2.15 ON RELATIONS WITH COMMANDERS AND MUJAHIDEEN

It is difficult to formulate guidelines for dealing with commanders, because the more they are involved in a program, the more they are tempted to interfere with it (this may or may not be a bad thing). A lot depends on the personalities of the commanders the committees choose to deal with.

For the health workers, the attitude of commanders is an important influence on the way a clinic functions. With good support and attention, a facility's operational needs are met and the clinics are running strongly. Support includes such things as financial assistance with the structure, money for clinic furnishings, wood for heating and cooking, food and cooking supplies, and maybe even transportation. Where such support is absent, whether by commander apathy or poverty, the clinics are generally grungy places with more limited services. The atmosphere in fact reflects the commander's level of interest and concern.

On the other hand, commander interest often means commander interference, as noted by instances of clinic location and patient services being directed at a group of mujahideen and not at the general population.

For the committees, it is important to know and understand the commanders that are receiving the health workers and clinics. Where a commander knows the committee, and the committee knows him, it is more likely that the commander will take care to see that a worker is working honestly.

2.16 ON DISTRICT HEALTH PLANNING

For health planning, it is more realistic to look at the district level than at the provincial level.

Most health workers and commanders agree that a reorganization of district-wide health care delivery is necessary, that there can be a central hospital facility with outlying ambulatory care clinics. All agree that such a health care network should serve the local population regardless of party differences.

On the remark that this might mean a currently existing clinic may diseappear, reactions differ:

* The health workers, if they have a place to work in a central facility, are ready to go there. It means a career and a sure future. They are willing to work across party lines, especially if their support committees approve it.

* The commanders are not ready to lose a clinic because it means, for them, losing power. They are less willing to work across party lines, especially if one commander's loss is someone else's gain. This is not to say the committees cannot bargain, especially if a trade-off is possible in the agricultural or education sectors.

Local political situations in Afghanistan predominate over other considerations in the implementation and management of any program.

Until there is a multilateral consensus among the local powers (amirs and commanders) in an area, centralization and coordination of public services including health care will be futile. A place to start may be to initiate discussions for planning a program at a place where power is already consolidated in one person or party.

Programs such as TB control, vaccination, public health, etc. should be planned as projects on a district level. Each program should be single and uniform, not having different committees running their own programs in the same place.

Without cooperation among the committees you can forget about meaningful district planning.

2.17 ON INTER-COMMITTEE FUTURE COOPERATIVE EFFORTS

CMC members have been able to work together on a variety of joint projects with good success, including producing a standard medicines list, producing a medical reference manual, green book analysis, and in-country medical monitoring.

It is our observation that the biggest need in the health care picture of Afghanistan is the need for the cross-border health care committees in Peshawar and Quetta to focus on continuing education for existing health workers, and to slack off on the current entry-level programs. STOP TRAINING AND PRODUCING SO MANY NEW HEALTH WORKERS, AND RECUPERATE THE EXISTING HEALTH WORKERS.

Someone must get the ball rolling in the other direction, because

A PLANNED HEALTH SYSTEM WILL NOT WORK IF THERE ARE NO GOOD DOCTORS AND NURSES TO WORK IN REFERRAL CENTERS AND TO SUPERVISE LOW- AND MID-LEVEL WORKERS.

The cross-border health committees must work to COORDINATE their programs because their workers overlap each other in the same areas. It is not possible for the health workers to coordinate themselves.

It is our observation that this coordination will not happen unless the agency funding the bulk of these programs, USAID, re-directs its thinking in regard to the programs and program goals it is willing to support. The scenario we see today in cross-border health care delivery is largely a consequence of the funding decisions USAID has made since 1984-85 when so many cross-border health care assistance programs were implemented.

Committee funding comes from a variety of sources. To some extent, the committees have self-direction in their goals and objectives. But the training programs are, let's face it, largely dependent on USAID funding and are training in ways that are in line with USAID program objectives. The picture today is a reflection of USAID program objectives in the past; and the picture tomorrow will reflect USAID program objectives in the present.

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For broad-based planning, the committees need to look outside of themselves and coordinate with a multitude of other assistance groups. This includes refugee assistance groups who are training health workers who will also one day be part of the local health care picture. And it includes groups providing assistance in areas other than health care, because at the local level there must be bargaining for allocation of resources.

Primary objectives now for the CMC committees should be COOPERATIVE EFFORTS on the acquisition of QUALITY INFORMATION and the establishment of SOLID RELATIONSHIPS with the people who are now administrating inside Afghanistan.